

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15007**

FILED MAY 8, 1944

Registration District No. **1032**

Primary Registration District No. **3032**

Registrar's No. **53**

1. PLACE OF DEATH:

(a) County **Johnson**
(b) City or town **Warrensburg**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Warrensburg Clinic
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **45 Minutes**
(Specify whether
in this community **45 Minutes**
years, months or days)

3. (a) PRINT
FULL NAME

Dean Hall
3. (b) If veteran, name war **No.** 3. (c) Social Security No. **No.**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married. **Single**
6. (b) Name of husband or wife 6. (c) Age of husband or wife If
alive years

7. Birth date of deceased **April 19 1944**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 hr. 45 min.

9. Birthplace **Warrensburg Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name **Howard James Hall**
13. Birthplace **Johnson Co. Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Ethel Frances Mathews**
15. Birthplace **Lafayette Co. Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Ethel Hall**
(b) Address **Higginsville Mo.**

17. (a) Burial **Yes** (b) Date thereof **4-21-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Earnestville Cem**

18. (a) Signature of funeral director **Sweeney Phillips**

(b) Address **Warrensburg, Mo.**

19. (a) **April 21, 1944** (b) **Dean M. Williams**
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Johnson** (b) County **Missouri**
(c) City or town **Warrensburg**
(If outside city or town limits, write "RURAL")
(d) Street No. **Warrensburg Clinic**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **19**
year **1944** hour **1** minute **45** P.M.

21. I hereby certify that I attended the deceased from **4-19-44**
to **4-19-44**, 19

that I last saw him alive on **4-19-44**, 19
and that death occurred on the date and hour stated above.

Immediate cause of death **prematurity**
Due to **polyhydramnios**
Due to **159**

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature **Dean M. Williams** (M. D. or other)
Address **Warrensburg, Mo.** Date signed **4-20-44**

Duration

6 mi.

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Was Not Embalmed

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Earl Priest*

Licensed Embalmer No. **3878**

P. O. Address. **Warrensburg, Mo.**

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.